

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1872 CERTIFICATE OF DEATH

Reg. Dist. No.

01865

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2/Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 Church Street		d. STREET ADDRESS 104 Church Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last B. Frank Adams		4. DATE OF DEATH February 21 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Adams		14. MOTHER'S MAIDEN NAME Louisa Dunn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-09-3255A	
17. INFORMANT Address Miss Flora Adams, 104 Church St. Elkton			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 5, 1957, to Feb. 21, 1960, that I last saw the deceased alive on Feb. 20, 1960, and that death occurred at 7:00 a. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE S. RALPH ANDREWS, M.D.		ADDRESS (Street, city or town, state) 233 E. Main St. DATE SIGNED 2/22/60	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, M.D.		Elkton Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/60	
22c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery		22d. LOCATION (City, town, or county) (State) Rising Sun, Cecil, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR DATE FEB 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	



# 1 1873 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL Elkton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>M.</b> Last <b>Anderson</b>		4. DATE OF DEATH Month <b>2</b> Day <b>19</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 12, 1869</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Elk Paper Mfg Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Anderson</b>		14. MOTHER'S MAIDEN NAME <b>Isabella Scarborough</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-18-1714</b>	
17. INFORMANT <b>Mrs Harvey M. Anderson</b>		Address <b>Elkton Rd 5 Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/17</b> , 19 <b>60</b> to <b>2/19</b> , 19 <b>60</b> that I last saw the deceased alive on <b>2/18</b> , 19 <b>60</b> , and that death occurred at <b>4:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Fair Hill Cecil Co., Md</b> DATE SIGNED <b>2/20/60</b>			
ACTUAL SIGNATURE <b>George J. Kries Jr</b> M.D.		PHYSICIAN'S NAME (Type) <b>George J. Kries Jr</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-23-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sharps Presby. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fair Hill Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b> ADDRESS <b>North East, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 23 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kries</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-282

CERTIFICATE OF DEATH

1973

MASSACHUSETTS DEPARTMENT OF HEALTH SERVICES

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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1874

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 21 Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 128 Collins St.		d. STREET ADDRESS 1128 Collins	
3. NAME OF DECEASED (Type or print) First Harry Middle Bessicks Last Bessicks		4. DATE OF DEATH February 16 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1889
9. AGE (In years lost, birthday) 70 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Bessicks	
14. MOTHER'S MAIDEN NAME Videlia Koons		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 212-16-1451		INFORMANT Address Mary A. Bessicks-128 Collins St.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Chronic Interstitial Nephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2- Yrs. 3- Yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/22/1959 to 2/16/1960 that I last saw the deceased alive on 2/15/1960, and that death occurred at 11 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James L. Johnson M.D. 245 East High, Street 2/18/60 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) James L. Johnson M. D. Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/60	
22c. NAME OF CEMETERY OR CREMATORY Providence Cem.		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 909 Poplar St.		24a. REC'D BY REGISTRAR DATE FEB 23 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hand			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01868

1893

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fredricktown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Fredricktown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SARAH</b> First <b>SALLIE</b> Middle <b>BIDDLE</b> Last				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 6, 1884</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Longer</b>				14. MOTHER'S MAIDEN NAME <b>Katie Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Wayman Biddle Jr.</b>		Address <b>Georgetown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>332</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of the right breastx. CVA 4 years ago due to cerebral thrombosis</b> 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Jan 59</b> , 19____, to <b>20 Feb 60</b> , 19____, that I last saw the deceased alive on <b>20 Feb 60</b> , 19____, and that death occurred at <b>4:20 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wallace G. Obenshain</b>				ADDRESS (Street, city or town, state) <b>Cecilton, Maryland</b>		DATE SIGNED <b>22 Feb 60</b>	
PHYSICIAN'S NAME (Type) <b>Wallace G. Obenshain, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 24, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cecilton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cecilton, Cecil Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Holloway, Mellington Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiser</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1894

01869

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>613 Race</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GOMAN</b> Middle <b>(NMI)</b> Last <b>BOOZE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-10-93</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	IF UNDER 24 HRS. Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert O. Booze (deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Annie Mills (deceased)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 218-14-1895</b>		INFORMANT Address <b>Rebecca Booze, wife, 613 Race Street, Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia bilateral unresolved</b> DUE TO (b) <b>491X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <b>491X</b> DUE TO (c) <b>491X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized severe</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>VA</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 10 1960</b> to <b>February 24 1960</b> and that death occurred at <b>3:55 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md. 2-25-60</b> DATE SIGNED <b>2-25-60</b>							
ACTUAL SIGNATURE <b>J. L. Garey</b>		PHYSICIAN'S NAME (Type) <b>J. L. GAREY Clinical Pathologist</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-29-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son, Perryville, Md.</b>				24a. REC'D BY REGISTRAR <b>FEB 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

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0913.2

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## CERTIFICATE OF DEATH

Reg. Dist. No. 96

03138

1895

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN lb <b>24 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>(NMI)</b> Last <b>BUCK</b>				4. DATE OF DEATH Month <b>February</b> Day <b>29</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-7-95</b>	
9. AGE (In years lost birthday) <b>64</b> yrs.		10. UNDER 1 YEAR Months <b>3</b> Days <b>0</b> Hours <b>0</b> Min.		11. UNDER 24 HRS. Hours <b>0</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Freight</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
13. FATHER'S NAME <b>Sam Buck (deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Louise Hines (deceased)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>unknown</b>			
17. INFORMANT <b>Earis L. Buck, wife, 1103 E. 43rd Street</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia (uremic poisoning)</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Pyelonephritis</b> DUE TO (c) <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>600.0</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>VA</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State) <b>Baltimore 28 Maryland</b>			
21. I certify that I attended the deceased from <b>February 5, 19 60</b> to <b>February 29 19 60</b> and that death occurred at <b>11:00 am</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>V.A. Hospital, Perry Point, Md. 2-29-60</b>							
ACTUAL SIGNATURE <b>J. L. Garey</b>				PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3/3/60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Williams</b>				24a. REC'D BY REGISTRAR <b>MAR 8 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

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1896  
CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>D.C.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Md.</b>			c. LENGTH OF STAY IN 1b <b>1mo. 17days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>HENRY (NMI) BUSH</b>			4. DATE OF DEATH Month Day Year <b>Feb. 2, 1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1894</b>	9. AGE (In years last birthday) <b>65</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock handler-Ret.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		
11. BIRTHPLACE (State or foreign country) <b>Edgefield, S. Car.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Bus</b>			14. MOTHER'S MAIDEN NAME <b>Henrietta Mitchell</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW1</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		
17. INFORMANT <b>Mrs. Dora Bush, (wife), N.W., Washington, D.C.</b>			Address <b>405 New York Ave</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage, cerebral, left</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardio vascular renal disease</b> DUE TO (c) <b>Arteriosclerosis, generalized, severe</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10-14 days</b> <b>Unk.</b> <b>Unk.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>12-15</b> , 19 <b>59</b> , to <b>2-2</b> , 19 <b>60</b> that last was the deceased's residence, and that death occurred at <b>4:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>James L. Garey</b>			M.D.		
PHYSICIAN'S NAME (Type) <b>JAMES L. GAREY, M.D.</b>			<b>VA HOSPITAL, PERRY POINT, MARYLAND</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>2/3/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>EDMUNDSON &amp; SON</b>			24a. REC'D BY REGISTRAR DATE <b>FEB 5 '60</b>		
ADDRESS <b>Havre de Grace, Md.</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trans</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF DEATH

1940

1. Name of deceased: [illegible]  
2. Date of death: [illegible]  
3. Place of death: [illegible]  
4. Cause of death: [illegible]  
5. Age at death: [illegible]  
6. Sex: [illegible]  
7. Race: [illegible]  
8. Marital status: [illegible]  
9. Occupation: [illegible]  
10. Education: [illegible]  
11. Religion: [illegible]  
12. Social Security Number: [illegible]  
13. Signature of declarant: [illegible]  
14. Date of statement: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1897 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01871

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> <span style="float: right;">b. COUNTY <u>Cecil</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fredericktown</u>			c. LENGTH OF STAY IN 1b <u>All life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <u>Fredericktown</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Addie</u> <span style="float: right;">First</span> <u>Lillian</u> <span style="float: right;">Middle</span> <u>Cohee</u> <span style="float: right;">Last</span>				<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-23-1878</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Galena. Md.</u>	
13. FATHER'S NAME <u>William Hicks</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Crisfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Jennie Kirk, Georgetown, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u>  <u>434.2</u> DUE TO            Cardiac Asthma            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Asthma</u>            DUE TO (c)         </div> <div style="width: 15%; text-align: center;">           INTERVAL BETWEEN ONSET AND DEATH   <u>years</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>2-15-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 18, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Galena Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Galena, Kent Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward S. Holloway, Hellington, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased _____		2. Sex _____		3. Age _____	
4. Date of Death _____		5. Time of Death _____		6. Place of Death _____	
7. Usual Residence _____		8. Present Residence _____		9. Occupation _____	
10. Cause of Death _____		11. Manner of Death _____		12. Signature of Medical Examiner _____	
13. Signature of Coroner _____		14. Signature of Registrar _____		15. Date of Filing _____	
16. Signature of Physician _____		17. Signature of Nurse _____		18. Signature of Undertaker _____	
19. Signature of Burial Director _____		20. Signature of Cemetery _____		21. Signature of Funeral Home _____	
22. Signature of Family _____		23. Signature of Friends _____		24. Signature of Community _____	
25. Signature of Church _____		26. Signature of School _____		27. Signature of Other _____	
28. Signature of State _____		29. Signature of County _____		30. Signature of City _____	
31. Signature of Town _____		32. Signature of Village _____		33. Signature of Hamlet _____	
34. Signature of Precinct _____		35. Signature of Ward _____		36. Signature of Block _____	
37. Signature of Lot _____		38. Signature of Parcel _____		39. Signature of Tract _____	
40. Signature of District _____		41. Signature of Division _____		42. Signature of Department _____	
43. Signature of Bureau _____		44. Signature of Office _____		45. Signature of Room _____	
46. Signature of Station _____		47. Signature of Post _____		48. Signature of Office _____	
49. Signature of Department _____		50. Signature of Bureau _____		51. Signature of Office _____	
52. Signature of Station _____		53. Signature of Post _____		54. Signature of Office _____	
55. Signature of Department _____		56. Signature of Bureau _____		57. Signature of Office _____	
58. Signature of Station _____		59. Signature of Post _____		60. Signature of Office _____	
61. Signature of Department _____		62. Signature of Bureau _____		63. Signature of Office _____	
64. Signature of Station _____		65. Signature of Post _____		66. Signature of Office _____	
67. Signature of Department _____		68. Signature of Bureau _____		69. Signature of Office _____	
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94. Signature of Station _____		95. Signature of Post _____		96. Signature of Office _____	
97. Signature of Department _____		98. Signature of Bureau _____		99. Signature of Office _____	
100. Signature of Station _____		101. Signature of Post _____		102. Signature of Office _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG258 3-8-60 et

1875

## CERTIFICATE OF DEATH

Reg. Dist. No.

01872

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 661674 Pleasant Hill</u>	
d. STREET ADDRESS <u>RFD # 3, Elkton</u> <u>Elkton, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>R.</u> Last <u>Craft</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18, 1876</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William T. Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Annie M. Curry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>Joseph L. Thompson, Elkton, Md. R.D. 3</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobes, lower right.</u> <u>490X</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>  </u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiac disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 12</u> , 19 <u>60</u> , to <u>Feb 17</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Feb. 17</u> , 19 <u>60</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. H. Q. preacher</u> M.D. <u>  </u>		DATE SIGNED <u>Feb 17-60</u>	
PHYSICIAN'S NAME (Type) <u>M. H. Sprecher</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Union, Cecil, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '60</u>	
ADDRESS <u>Elkton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1922

DEATH RECORD

Age at death

Blank form with horizontal lines for text entry.

14  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

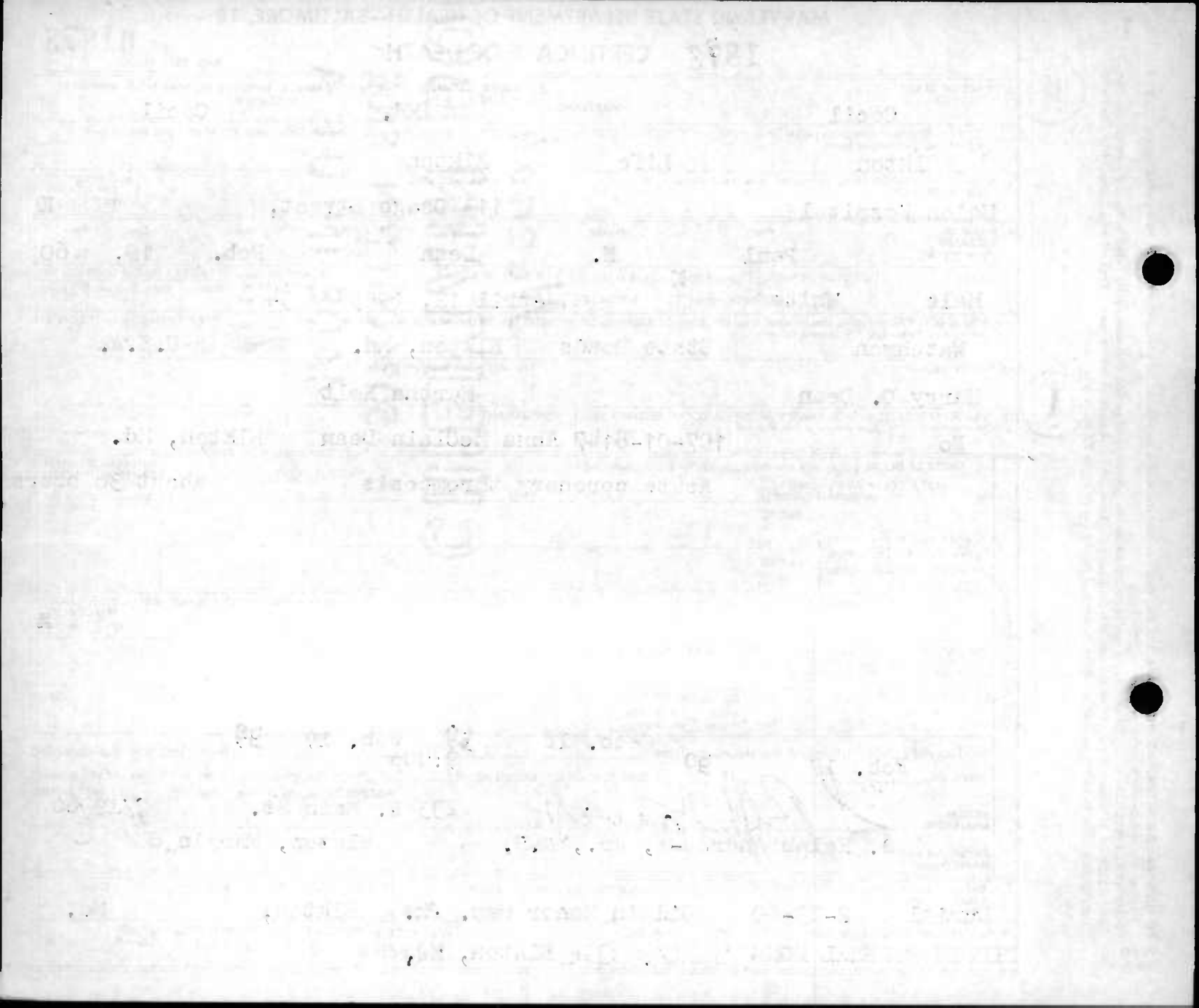
1876 CERTIFICATE OF DEATH

01873

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>H.</b> Last <b>Dean</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 12, 1905</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months <b>54</b> Days <b>54</b> Hours <b>54</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Elkton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>State Roads</b>			
13. FATHER'S NAME <b>Harry O. Dean</b>				14. MOTHER'S MAIDEN NAME <b>Martha Holt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>197-01-8147</b>			
17. INFORMANT <b>Anna McClain Dean</b>				Address <b>Elkton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> DUE TO <b>Acute coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>about 36 hours</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Feb. 18 59</b>				20f. (City or town) (County) (State) <b>Feb. 19 59</b>			
21. I certify that I attended the deceased from <b>Feb. 18 59</b> to <b>Feb. 19 59</b> , that I last saw the deceased alive on <b>Feb. 19 59</b> , and that death occurred at <b>9:00p</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr., M.D.</b>				ADDRESS (Street, city or town, state) <b>233 E. Main St. Elkton, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>S. Ralph Andrews, Jr., M.D.</b>				DATE SIGNED <b>2/19/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-23-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Mem. Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>				24a. REC'D BY REGISTRAR <b>Donald A. Dee</b>			
ADDRESS <b>Elkton, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Feb 24 '60</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>28yrs.8mo.8days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				f. STREET ADDRESS <b>Rt.#3, Box 215, Sandy Plains Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>S.</b> Last <b>DILWORTH</b>				4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-22-90</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>			
13. FATHER'S NAME <b>Not available from records</b>				14. MOTHER'S MAIDEN NAME <b>Not available from records</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>unknown</b>			
17. ADDRESS <b>Plains Road, Dundalk, Md.</b>				18. ADDRESS <b>Edith Burns, Aunt, Rt.#3, Box 215, Sandy</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Azotemia</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Pyelonephritis, bilateral, with abscesses</b> DUE TO (c) <b>Calculus urethra and urinary bladder</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>unknown</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 15</b> 19 <b>31</b> to <b>February 23</b> 19 <b>60</b> and that death occurred at <b>2:40p</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. L. Garey</b>				DATE SIGNED <b>2-25-60</b>			
PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>				ADDRESS (Street, city or town, state) <b>M.D. V.A. Hospital, Perry Point, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>2/26/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>				ADDRESS <b>Havre de Grace, Md.</b>			
24a. REC'D BY REGISTRAR <b>MAR 2 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1899

CERTIFICATE OF DEATH

01875

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> M				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>1 yr. 3mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <b>605 Wilson Avenue</b>							
3. NAME OF DECEASED (Type or print) First <b>CLEMENT</b> Middle <b>(NMI)</b> Last <b>DROHOVITH</b>				4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-18-70</b>	9. AGE (In years lost birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Not obtainable</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>(Not available from records)</b>				14. MOTHER'S MAIDEN NAME <b>(Not available from records)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> If yes, give war or dates of service <b>S.A.W.</b>				16. SOCIAL SECURITY NO. <b>unknown</b> INFORMANT Address <b>Superior, Wisc. 708 Grand Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyelonephritis, right, with multiple abscess formation</b> 181.0 DUE TO (b) <b>Carcinoma of urinary bladder recurrent, and obstruction to the ureters.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> attended the deceased from <b>November 6, 1958</b> , to <b>February 6, 1960</b> , and that death occurred on <b>February 6, 1960</b> at <b>9:35 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>2-9-60</b>							
ACTUAL SIGNATURE <b>J. L. Garey</b>				PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b> <b>Clinical Pathologist</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>2/11/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>				ADDRESS <b>Havre de Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 17 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			

2

1

050

03X-2

1303  
CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]

10. Signature of informant: [illegible]  
11. Date of completion: [illegible]  
12. Registrar's office: [illegible]  
13. Registrar's name: [illegible]  
14. Registrar's title: [illegible]  
15. Registrar's address: [illegible]

16. Registrar's stamp: [illegible]  
17. Registrar's signature: [illegible]  
18. Registrar's title: [illegible]  
19. Registrar's address: [illegible]  
20. Registrar's phone: [illegible]  
21. Registrar's fax: [illegible]  
22. Registrar's email: [illegible]  
23. Registrar's website: [illegible]  
24. Registrar's social media: [illegible]  
25. Registrar's contact information: [illegible]

1877

## CERTIFICATE OF DEATH

01876

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. Dela. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS -	
3. NAME OF DECEASED (Type or print) First Middle Last Mona Lynn Eldreth		4. DATE OF DEATH Month Day Year Feb. 17, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1960
9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Smith Eldreth		14. MOTHER'S MAIDEN NAME Helen Marie Mc Craw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Mr. Fred S. Eldreth, Newark, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 15 Feb, 1960, to 17 Feb, 1960, that I last saw the deceased alive on 17 Feb, 1960, and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clifton R. Brooks		ADDRESS (Street, city or town, state) DATE SIGNED Union Hosp., Elkton, Md.	
PHYSICIAN'S NAME (Type) Clifton R. Brooks, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 20, 1960	22c. NAME OF CEMETERY OR CREMATORY Pk. Elkton, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR ADDRESS 24 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2065233XVO

1871  
CERTIFICATE OF DEATH

John Smith

1871

John Smith

1900  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Warwick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Warwick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIZA</b> Middle <b>ELLEN</b> Last <b>EMORY</b>		4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 7 1880</b>
9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Sassafras Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Ireland</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mary E. Camile,</b>		Address <b>Golt, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> <b>466X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Peripheral thrombosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>2 days.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cholecystectomy Feb 2 but was recovered.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 59</b> , 19____, to <b>21 Feb 60</b> , 19____, that I last saw the deceased alive on <b>21 Feb 60</b> , 19____, and that death occurred at <b>3:05A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cecilton, Maryland</b> DATE SIGNED <b>22 Feb 60</b> ACTUAL SIGNATURE <b>Wallace Obenshain M.D.</b> PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 24, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cecilton Cemetery.</b>		22d. LOCATION (City, town, or county) (State) <b>Cecilton, Cecil Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward G. Hallowell, M.D.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 24 '60</b>	
ADDRESS <b>Arthur S. Hallowell</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hallowell</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01878

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">1878</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN lb <u>11 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Port Deposit</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Rebecca W. England</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>2 8 19 60</u>															
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 23 1909</u>		<b>9. AGE</b> (In years last birthday) <u>50</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																	
Months	Days	Hours	Min.																
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>											
<b>13. FATHER'S NAME</b> <u>Edward T. Williams</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Lydia Garrett</u>															
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>-</u>		<b>17. INFORMANT</b> Address <u>Edward Thomas Williams Elkton, Md</u>															
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="vertical-align: top;"> <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b>  <u>260x</u> <b>DUE TO</b> <u>Cerebral Hemorrhage</u> </td> <td colspan="2" style="vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>11 hours</u> </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>DUE TO</b> <u>Hypertension</u> </td> <td colspan="2" style="vertical-align: top;"> <u>3 years</u> </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> <b>DUE TO</b> <u>Diabetes</u> </td> <td colspan="2" style="vertical-align: top;"> <u>3 years</u> </td> </tr> </table>								<b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <u>260x</u> <b>DUE TO</b> <u>Cerebral Hemorrhage</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>11 hours</u>		<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>DUE TO</b> <u>Hypertension</u>		<u>3 years</u>		<b>DUE TO</b> <u>Diabetes</u>		<u>3 years</u>	
<b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <u>260x</u> <b>DUE TO</b> <u>Cerebral Hemorrhage</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>11 hours</u>																	
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>DUE TO</b> <u>Hypertension</u>		<u>3 years</u>																	
<b>DUE TO</b> <u>Diabetes</u>		<u>3 years</u>																	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>																			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1b.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>													
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/>. and find that death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>.</b>																			
<b>ACTUAL SIGNATURE</b> <u>R.C. Dodson</u> <b>EXAMINER'S NAME (Type)</b> <u>R.C. Dodson</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>2-11-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>West Nottingham</u>		<b>22d. LOCATION (City, town, or county) (State)</b> <u>Colorado Cecil Co. Md</u>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph R. Grant</u> <b>ADDRESS</b> <u>North East, Maryland</u>				<b>24a. REC'D BY REGISTRAR</b> <u>FEB 11 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1879

## CERTIFICATE OF DEATH

Reg. Dist. No.

01879

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cecilton</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Fathy Juvenita</i> First <i>Foreaker</i> Middle Last		4. DATE OF DEATH Month <i>Feb</i> Day <i>12</i> Year <i>1960</i>	
5. SEX <i>7</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 1st 1959</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Cecilton Maryland W. S. A.</i>
13. FATHER'S NAME <i>Franklin D. Foreaker</i>		14. MOTHER'S MAIDEN NAME <i>Mary Keaton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Franklin D. Foreaker</i> ADDRESS <i>Warwick Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspirational Pneumonia</i> <i>744.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <i>Amotonia Congenita</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks birth</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct</i> , 19 <i>59</i> , to <i>12 Feb</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>12 Feb</i> , 19 <i>60</i> , and that death occurred at <i>10:45</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wallace Oberheim</i> M.D.		ADDRESS (Street, city or town, state) <i>Cecilton, Md</i> DATE SIGNED <i>15 Feb 60</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>2/15/1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cecilton Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Cecilton Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Walter duBois</i> ADDRESS <i>Cecilton Md</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 18 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2065293XV5

CERTIFICATE OF DEATH

DECEASED

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

SIGNATURE OF CLERK

SIGNATURE OF JUDGE

1880

CERTIFICATE OF DEATH

01880

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Union Hosp.</u>		e. STREET ADDRESS <u>2nd St Extended</u>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>L.</u> Last <u>Hallam</u>		4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/74</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin Willett</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Bishop</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease 1 yr.</u> (c) <u>Coronary Thrombosis</u> 4 days		INTERVAL BETWEEN ONSET AND DEATH <u>1 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 26, 1959</u> to <u>Feb 2, 1960</u> , that I lost saw the deceased alive on <u>Feb. 2, 1960</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph J. Lanz</u>		ADDRESS (Street, city or town, state) <u>205 W Main St ELKTON Md 3/2/60</u>	
PHYSICIAN'S NAME (Type) <u>Joseph G. Lanz</u>		DATE SIGNED <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-5-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Silverbrook Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Wilmington, Delaware</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. Hanning</u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>  </u>	
ADDRESS <u>20 Paisley Drive Wilmington 8, Delaware</u>		DATE <u>FEB 5 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]  
11. Date of registration: [illegible]

COUNTY  
Cecil

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☒

Day 26 Year 1960

Months	Days	Hours	Min.
--------	------	-------	------

U S A

Price

Alexander Hasson, Perryville, Md.

8 mont  
19/2/20

(c)

PERFORMED?  
YES ☐ NO ☐

(State)

DATE SIGNED \_\_\_\_\_

✓

(State)

24b. REGISTRAR'S SIGNATURE

Arthur S. Evans

1001

2.7

12.2

1.1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01882

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elkton, R.D.1.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ricky		4. DATE OF DEATH Month 2 Day 13 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-59
9. AGE (In years last birthday) yrs. 5		10. IF UNDER 1 YEAR Months 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Lancaster, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel H arley Holmfield		14. MOTHER'S MAIDEN NAME Bernice Prewitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 17. INFORMANT Address Samuel Harley Holmfield, Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus Infection DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-13-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/16/60	
22c. NAME OF CEMETERY OR CREMATORY Bouldens Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Cecil, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Nicks		24a. REC'D BY REGISTRAR DATE FEB 26 '60	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 2 3 4 5

111

CERTIFICATE OF DEATH

Reg. Dist. No.

01883

1882

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EIKTON</i>				c. LENGTH OF STAY IN 1b <i>9 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>21 EIKTON</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>UNION Hospital</i>				d. STREET ADDRESS <i>Bow street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>CORA</i> Middle <i>B.</i> Last <i>HOUCK</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>7</i> Year <i>1960</i>		5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 30, 1872</i>		9. AGE (In years lost birthday) yrs. <i>87</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Delaware</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James W. Jackson</i>				14. MOTHER'S MAIDEN NAME <i>Emma Guessford</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		INFORMANT <i>Edna I. Houck, Baltimore, md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) <i>Fracture of rt leg &amp; rt femur</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>Years.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 8</i> , 19 <i>59</i> , to <i>1960</i> , that I last saw the deceased alive on <i>7 Feb.</i> , 19 <i>60</i> , and that death occurred at <i>7:35</i> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Wallace Obenshain</i> M.D.				ADDRESS (Street, city or town, state) <i>Cecil, Md.</i>		DATE SIGNED <i>7 Feb 1960</i>	
PHYSICIAN'S NAME (Type) <i>Wallace Obenshain, md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-10-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Bethel Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>nr. Chesapeake City, md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pippin Funeral Home Donald J. De EIKTON, MD</i>				24a. REC'D BY REGISTRAR <i>FEB 10 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Caroline S. Kline</i>	

1152

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

1928

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

1

RECEIVED BY THE  
STATE DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 4 hours after death. Pages 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01884

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>1883</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b> c. LENGTH OF STAY IN 1b <b>1 Week</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CECIL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LAURA</b> First <b>BELLE</b> Middle <b>HUSS</b> Last 4. DATE OF DEATH <b>2/ 20/ 1960</b> Month <b>2</b> Day <b>20</b> Year <b>1960</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>11/ 27/ 1880</b> 9. AGE (In years lost birthday) <b>79</b> yrs. 10. IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b> 11. BIRTHPLACE (State or foreign country) <b>Cecil Co. Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Ritchie</b> 14. MOTHER'S MAIDEN NAME <b>Evelyn Reed</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Mrs. Mary Flaharty Port Deposit, Md.</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>570.4 ACUTE INTESTINAL OBSTRUCTION</b> DUE TO <b>FECAL IMPACTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>LARGE HERNIA OF ABD. WALL</b> DUE TO <b>70 years?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchiectasis + pulmonary atelectasis, pneumonia</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>2-12</b> , 19 <b>60</b> , to <b>2-19</b> , 19 <b>60</b> that I last saw the deceased alive on <b>2-19</b> , 19 <b>60</b> , and that death occurred at <b>10:55 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Elkton Md.</b> DATE SIGNED <b>2-20-60</b> ACTUAL SIGNATURE <b>Peter Stank</b> M.D. <b>ELKTON Md.</b> PHYSICIAN'S NAME (Type) <b>P. STAVRAKIS M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>2/ 23/ 1960</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cem.</b> 22d. LOCATION (City, town, or county) (State) <b>Oakwood Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas E. Muller</b> ADDRESS <b>Rising Sun, Md.</b> 24a. RECEIVED BY REGISTRAR <b>FEB 23 60</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>	

# CERTIFICATE OF DEATH

1923

State of New York

County of Albany

On the 12th day of January, 1923, at the City of Albany, New York, I, the undersigned, a duly qualified and licensed physician, do hereby certify that the within and foregoing is a true and correct statement of the facts and circumstances surrounding the death of the person named therein, and that the same was caused by the disease or diseases therein stated.

Witness my hand and the seal of my office, this 12th day of January, 1923.

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Minister of the Gospel

Signature of Justice of the Peace

Signature of Notary Public

Signature of Health Officer

Signature of School Board

Signature of Board of Education

Signature of Board of Health

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Elkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Elisa Johnson</u>		4. DATE OF DEATH Month Day Year <u>Feb 4 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1890</u> 9. AGE (In years last birthday) <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Wilmington, Dela.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Alfred Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Sally Langley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unk.</u>		INFORMANT Address <u>The Deceased</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 241X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Bronchopneumonia</u> (c) <u>Bronchial asthma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>5 d.</u> <u>Several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 31, 1960</u> , to <u>Feb 4, 1960</u> , that I last saw the deceased alive on <u>Feb 4, 1960</u> , and that death occurred at <u>12:37 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Tillman D. Johnson M.D.</u>		ADDRESS (Street, city or town, state) <u>123 Singlerly Ave., Elkton</u>	
PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/7/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cecil County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24a. REC'D BY REGISTRAR <u>Feb 17 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

01886

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b 33yrs.2mo.2days		1556.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 501 Sligo Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN E. LEWIS		4. DATE OF DEATH Month Day Year February 8 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-92
9. AGE (In years lost birthday) yrs. 67		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Veterans Administration	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George S. Lewis		14. MOTHER'S MAIDEN NAME Eliza M. Hayward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Peacetime		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs. Helen I. Lewis, wife, 501 Sligo Avenue		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Bronchopneumonia left lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarcts small left lung, origin uncertain DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 3-4 days 3-4 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 7, 1926, to February 8, 1960, that last on the second day of February, 1960, at 5:50 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. L. Garey		DATE SIGNED 2-9-60	
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 2/10/60	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS Pennington & Son, Havre de Grace, Md.		24b. REGISTRAR'S SIGNATURE	
DATE FEB 17 '60		Arthur S. Harris	

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02238

STATE OF TEXAS

County of ...  
City of ...  
I, the undersigned, Clerk of the County of ...  
do hereby certify that ...  
Witness my hand and the seal of said County at the City of ...  
this ... day of ... 19...

Attest:  
Clerk of the County of ...  
My Commission Expires ...

Witness my hand and the seal of said County at the City of ...  
this ... day of ... 19...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18 Film 267 7-25-60 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										01887	
1885										CERTIFICATE OF DEATH	
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>					c. LENGTH OF STAY IN 1b <u>1 WK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WARWICK (RURAL)</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>					d. STREET ADDRESS <u>RD #2 MIDDLETOWN DELAWARE</u>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>A.</u> Last <u>Lockerman</u>					4. DATE OF DEATH Month <u>Feb</u> Day <u>22</u> Year <u>1960</u>						
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 30, 1917</u>		9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>VANDORN LAWRENCE</u>					14. MOTHER'S MAIDEN NAME <u>LILLIAN BEPWELL</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT <u>JULIAN LOCKERMAN RD #2 MIDDLETOWN DEL.</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> <u>410 X</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Rheumatic mitral valvulitis with stenosis, inactive</u> DUE TO (c) <u>Rheumatic mitral valvulitis with stenosis, inactive</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic mitral valvulitis with stenosis, inactive</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>60</u> , to <u>22 Feb</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>22 Feb</u> , 19 <u>60</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Wallace Chenehan M.D.</u>					ADDRESS (Street, city or town, state) <u>WARWICK MARYLAND</u> DATE SIGNED <u>22 Feb 1960</u>						
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>FEB 26, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WARWICK CEMETERY</u>			22d. LOCATION (City, town, or county) (State) <u>WARWICK MARYLAND</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u> ADDRESS <u>ELKTON MD</u>					24a. REC'D BY REGISTRAR <u>FEB 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>				

CERTIFICATE OF DEATH

1902

WILLIAM H. HOWE

114 1/2 W. 14th St.

CHICAGO, ILL.

Nov 20 1902

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XChesapeake City,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last MK JOHN J. MALONEY		4. DATE OF DEATH Month Day Year February 28, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1893
9. AGE (In years lost birthday) 66 yrs.		10. BIRTHPLACE (State or foreign country) Maryland	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oil Business		12. CITIZEN OF WHAT COUNTRY? USA	

13. FATHER'S NAME James Maloney		14. MOTHER'S MAIDEN NAME Ella Gracey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW # 1		16. SOCIAL SECURITY NO. 152-07-2595	
17. INFORMANT Mrs. Kathryn S. Maloney		Address Chesapeake City Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO JAUNDICE (b) CARCINOMA OF LIVER (c) <u>underlying</u> cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 10, 1960, to Feb. 28, 1960, that I last saw the deceased alive on Feb. 28, 1960, and that death occurred at 10:30 P.M. from the causes and on the date stated above.		DATE SIGNED 2/28/1960
ACTUAL SIGNATURE Henry V. Davis		ADDRESS (Street, city or town, state) Chesapeake City, Md.
PHYSICIAN'S NAME (Type) Henry V. Davis		M.D. Henry V. Davis

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/3/1960	22c. NAME OF CEMETERY OR CREMATORY St. Roses Cemetery	22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Full Name

Place of Birth

Age

Date of Death

Sex

Marital Status

Occupation

Signature of Registrar

Date

Signature of Deceased

Page

Page

Signature of Registrar

Date

Signature of Deceased

Signature of Registrar

Date

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		1887		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle Last Nokes		4. DATE OF DEATH Month 2 Day 23 Year 1960			
5. SEX M	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1900	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Rachel Nokes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-18-6339		INFORMANT Address Rachel Nokes-Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 152.0 Adenocarcinoma of ileum DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/23, 1960, to 2/23, 1960, that I last saw the deceased alive on 2/23, 1960, and that death occurred at 10:00 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE John A. Fischer		M.D. 162 W MAIN ST. EIKTON, Md		ADDRESS (Street, city or town, state) DATE SIGNED 2/24/60	
PHYSICIAN'S NAME (Type) John A. Fischer					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/29/60	22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor, Cem.		22d. LOCATION (City, town, or county) (State) Bohemia Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John P. Bell		ADDRESS 909 Poplar St.		24a. REC'D BY REGISTRAR DATE MAR 1 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF ANALYSIS

1937

ANALYST

DATE

TIME

PLACE

REMARKS

TEST

RESULT

CONCLUSION

SIGNATURE

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STATE

CITY

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01890

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil 1888 MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Cecil Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital			d. STREET ADDRESS 309 1/2 King St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Samuel Thomas Price			4. DATE OF DEATH Month 2 Day 23 Year 19 60		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-1902		9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elect. Maintance		10b. KIND OF BUSINESS OR INDUSTRY Thiocol		11. BIRTHPLACE (State or foreign country) Pa.	
13. FATHER'S NAME M. Reed Price			14. MOTHER'S MAIDEN NAME Hannah Michaels		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Isaac Price, Phillips burg. Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest, Fracture base of skull, left femur tibia and fibula right wrist lower left maxilla laceration of left leg, both lower at knee and thigh also right right leg. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Motor vehicle acc. with motor veh.			
20c. TIME OF INJURY Month, Day, Year 2 23 60		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 284 and 40 Elkton Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-24-66	
EXAMINER'S NAME (Type) R.C. Dodson					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-24-60		22c. NAME OF CEMETERY OR CREMATORY Phillipsburg Cemetery Phillipsburg, Penna	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR FEB 26 '60		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil 1889 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 5 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East, Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louise Shipley				4. DATE OF DEATH Month Day Year 2 1 1960			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-1889		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME no information				14. MOTHER'S MAIDEN NAME No information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218-32-019		17. INFORMANT Mrs Atlee Armour Address Rising Sun Rd. Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		2-2-1960	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-5-1960		22c. NAME OF CEMETERY OR CREMATORY Hopewell Methodist		22d. LOCATION (City, town, or county) (State) Rising Sun Cecil Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR FEB 4 1960	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanks			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SANDY</b> Middle <b>A.</b> Last <b>TAMARGO</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-5-87 1889</b>	
9. AGE (In years last birthday) <b>70 1/2</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sandalio Tamargo (deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Meisner (deceased)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>212-22-0693</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Bronchopneumonia left lower lobe</b> (c) <b>Arteriosclerotic heart disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>February 20, 1960</b> , to <b>February 24, 1960</b> , and that death occurred at <b>7:30p</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. L. Garey</b>				DATE SIGNED <b>2-25-60</b>			
PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>				ADDRESS (Street, city or town, state) <b>VA. A. Hospital, Perry Point, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>2-28-60</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Charlestown</b>		22d. LOCATION (City, town, or county) (State) <b>Charlestown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>				ADDRESS <b>Home, Northeast, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 29 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Grant</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

UNITED STATES OF AMERICA

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## CERTIFICATE OF DEATH

Reg. Dist. No.

01893

1890

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hacks Point</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary First DuHammell Last Taylor.</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Kent Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Du Hamell</b>		14. MOTHER'S MAIDEN NAME <b>Ella Teat</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>221-09-6610</b>	
17. INFORMANT <b>Bessie T. Rauch, Hacks Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>coronary occlusion about 5 weeks prior to death.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 2 1969</b> , 19 <b>Feb 12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>12 Feb 60</b> , and that death occurred at <b>400 am</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b> DATE SIGNED <b>15 Feb 60</b>			
ACTUAL SIGNATURE <b>Wallace Obenshain M.D.</b>			
PHYSICIAN'S NAME (Type) <b>wallace Obenshain, M.D.</b> <b>Cecilton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-15-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chester Rural Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chester, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>		24a. REC'D BY REGISTRAR <b>Feb 16 '60</b>	
ADDRESS <b>Elkton, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)  
ISM 9/58

1941

MAINTAIN STATE OF MIND AND BE AWARE OF THE FACTS

LETTER OF DEATH

1981

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G257 2-26-60 et  
1871 CERTIFICATE OF DEATH

01894

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>				c. LENGTH OF STAY IN 1b <u>36 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lewis St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Armstrong Thornton</u>				4. DATE OF DEATH Month Day Year <u>Feb 15 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1905</u>		9. AGE (In years last birthday) <u>54 yrs.</u>	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat Captain</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dredge Boat</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Thornton</u>				14. MOTHER'S MAIDEN NAME <u>Emma Elizabeth Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>091-01-8227</u>		INFORMANT <u>Widow</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the bladder with metastases</u> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>15 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 3</u> , 19 <u>60</u> , to <u>Feb 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 3</u> , 19 <u>60</u> , and that death occurred at <u>12:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. Johnson</u>				ADDRESS (Street, city or town, state) <u>123 Singlerly Ave Elkton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>T. Johnson</u>				DATE <u>FEB 19 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/18/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WA. CHESAPEAKE CITY Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home Donald R. Du</u>				ADDRESS <u>ELKTON, Md</u>		24a. REC'D BY REGISTRAR <u>FEB 19 1960</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 48 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1871

No. 1

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## 1891 CERTIFICATE OF DEATH

01895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b <u>22 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSP</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LEWIS</u> Middle <u>WALLS</u> Last <u>WALLS</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 15, 1903</u>		9. AGE (In years last birthday) <u>56</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MAINTENANCE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS WALLS</u>				14. MOTHER'S MAIDEN NAME <u>ANNA HORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-14-6220</u>		INFORMANT <u>Mrs MARTHA WALLS</u>		Address <u>ELKTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>28 Jan.</u> , 19 <u>60</u> , to <u>3 Feb.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3 Feb.</u> , 19 <u>60</u> , and that death occurred at <u>4:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Klaus H. Hecker</u>				ADDRESS (Street, city or town, state) <u>North E. St. 124</u>		DATE SIGNED <u>3 Feb '60</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Hecker M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB 6, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ELKTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ELKTON Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME Donald P. Pippin</u>				ADDRESS <u>ELKTON, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Thomas</u>	
				DATE <u>FEB 10 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1904 CERTIFICATE OF DEATH

Reg. Dist. No. 96

01896

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>28 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>7422 Georgia Avenue, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>M.</b> Last <b>WHITE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-12-1900</b>
9. AGE (In years lost birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>59</b>	11. IF UNDER 24 HRS. Days <b>16</b> Hours <b>16</b> Min. <b>16</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	11. BIRTHPLACE (State or foreign country) <b>D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Herbert M. White (deceased)</b>	
14. MOTHER'S MAIDEN NAME <b>Bertha Nightingale (deceased)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>Elsie B. White (Wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the stomach with widespread metastases to the regional lymph nodes and liver</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. 151X DUE TO (b) <b>liver</b> DUE TO (c) <b>liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County)	
20g. (State)		20h. (Country)	
21. I certify that I attended the deceased from <b>January 19, 1960</b> , to <b>February 16, 1960</b> , and that death occurred at <b>4:55 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4:55 a.m.</b> DATE SIGNED <b>2-16-60</b>			
ACTUAL SIGNATURE <b>J. L. Garey</b>		M.D. V.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/19/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner Pumphrey</b>		24a. REC'D BY REGISTRAR <b>FEB 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

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silence.

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## 1905 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point,</b> c. LENGTH OF STAY IN 1b <b>14 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington,</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>634 N. St., N.W.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>SAMUEL (NMI) WHITT</b>				4. DATE OF DEATH Month Day Year <b>Feb. 3, 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/26/1900</b> <b>Feb. 3, 1960</b>	
9. AGE (In years lost birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night clerk-hotel</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Reidsville, S.Car.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Whitt</b>	
14. MOTHER'S MAIDEN NAME <b>Jenny (unknown)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>634 N. St., N.W.,</b> <b>Chauncey Whitt(B), Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rectal resection for adenocarcinoma, 2/3/60</b> DUE TO (c) <b>Cirrhosis of the liver.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>About 45 min.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 21, 1960</b> to <b>Feb. 3, 1960</b> , and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>J. L. Garey</b> PHYSICIAN'S NAME (Type) <b>J. L. GAREY, M. D.</b>				M.D. <b>VA Hospital, Perry Point, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2/5/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b> ADDRESS <b>Havre de Grace, Md.</b>				24a. REC'D BY REGISTRAR <b>FEB 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12303 CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 19 hourd			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Beverly		Middle Gail		Last Wood		4. DATE OF DEATH Month February Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-15-1960		9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Elkton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herbert M. Wood				14. MOTHER'S MAIDEN NAME Eleanor Anne Dennis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		INFORMANT Address Herbert M. Wood North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.0 Pulmonary Hyaline Membrane Disease DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) - (c) -						INTERVAL BETWEEN ONSET AND DEATH 19 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. - 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) - (County) - (State) -	
21. I certify that I attended the deceased from 15 Feb, 1960, to 16 Feb, 1960, that I last saw the deceased alive on 16 Feb, 1960, and that death occurred at 3:20 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huebner		M.D. North East, Md		ADDRESS (Street, city or town, state)		DATE SIGNED 2/16/60	
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-17-1960		22c. NAME OF CEMETERY OR CREMATORY North East Methodist		22d. LOCATION (City, town, or county) (State) North East Cecil Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant North East Maryland				24a. REC'D BY REGISTRAR DATE FEB 19 '60		24b. REGISTRAR'S SIGNATURE Clinton S. Thomas	

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# CERTIFICATE OF DEATH

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*[Faint, mostly illegible text on a form, likely containing fields for name, date, and cause of death.]*

